IHS Integrated Diabetes Education Recognition Program
Sample Annual Program Plan

Annual Program Plan
January 2001 to December 2001

Statement of Support
The Board of Directors and medical community of (Name of Facility) strongly believe that self-management education is an integral component in the care of people with diabetes. (Name of Facility) will continue to provide adequate personnel, resources and meeting space to meet the needs of the population it serves. We support the staff and their commitment to improve the lives of people with diabetes in the community.

Program Description
Based on the results of our program review conducted November 8, 2000 (Name of Diabetes Education Program) will continue to offer a 6-hour outpatient group class each month at (Name of Facility), plus individual instruction for inpatients, gestational patients and pediatric patients. Entry into the program involves a one-hour individual educational needs assessment. If classroom education is not convenient and/or appropriate, one-to-one instruction is provided.

Program Objectives
Based on the action plans for the 2000 annual review, the program objectives for 2001 are:
1. To increase the number of program participants by 20% from last year
2. To increase the program completion rate of 20% from last year
3. 50% of participants will receive follow-up 3 to 6 months following completion of education intervention
4. To finalize the standardization of patient handouts into one participant notebook

Instructional Methods
Instructional methods include facilitated group discussion, individual discussion, demonstrations and hands-on practice and audiovisual presentations. Participant involvement is encouraged through individual needs assessment and setting individualized learning objectives.

Target Population
The target population for our program includes all people with diabetes (type 1, type 2 and gestational) and their families in (list communities). The target population includes about (#) of new cases per year. This population is predominately (describe), is bilingual (list languages) and has diverse education levels and socioeconomic status. Approximately 10% have low literacy needs and 30% are elderly.

Participant Access
Participants access the program through referral from their primary care provider. Individuals or other health care providers may request a referral to the program form the primary care provider.

Follow-up
Follow-up is integral to the successful behavior change and will be conducted at 3 month intervals for one year following educational intervention and then yearly thereafter. More frequent follow-up will be conducted based on individual needs. If participants are unable to keep their follow-up appointments, the educator will do a phone assessment. The follow-up visit will include an assessment of health status, knowledge, skill and attitudes, behavioral goal achievement and post-program A1c results.

Resource Requirements
Program resources, including classroom space for group activities, are adequate. We need to continually evaluate the adequacy of office space to meet with participants and family members individually. Program staff remains tight with more people being referred into the program. Additional hours have been requested for a diabetes nurse educator.

Outcome Measures
In addition to tracking participant achievement of behavioral goals, the program will continue to compare HbA1c values pre and post program. This year we will also track pre and post program completion of sensory foot exams and dilated eye exams. Goals and measurements are:

1. 75% of participants will be successful with achievement of their personal behavior change goals
2. 75% of participants will have and A1c value of less than 7%
3. 90% of participants will have an annual sensory foot exam
4. 90% of participants will have an annual dilated eye exam

The Diabetes Education Advisory Committee and (Name of Facility) approve the annual program plan for 2001.

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Name of Diabetes Education Program Coordinator/Advisory Committee Chair Date

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Name of Clinical Director Date

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Name of Chief Executive Officer of Facility Date

Source: IHS Integrated Diabetes Education Recognition Program Sample Materials

IHS Integrated Diabetes Education Recognition Program
Sample Annual Program Plan

Annual Program Plan
August 2001 to June 2001
Albuquerque Service Unit Diabetes Education Program

Statement of Support
The Albuquerque Indian Hospital (AIH) Executive Board and the hospital staff believe in the importance of diabetes education for our patients. Patients, families and communities should be provided with up-to-date and culturally sensitive education services.

In light of the new reimbursement opportunities through Medicare, we will be moving to more group Education but will still offer one-to-one education when it is more appropriate. Education services will continue to be offered for all diabetes patients, with a focus on newly diagnosed diabetes patients and pregnant diabetes patients. Other services, such as community education programs, will continue to be provided.

- Program Objectives

Based on the action plans for the annual review, the program objectives for the coming year are:

1. Convert from one-to-one education to group education for newly diagnosed diabetes patients
2. Apply for IHS National Diabetes Program Review
3. Maintain education program administration, including implementation of *Basics Plus* tracking program
4. Obtain reimbursement for patients in the Diabetes Education Program

- Target Population

The target population is all newly diagnosed patients and their families who are eligible for service at AIH. We also provide education for all other patients with diabetes and their families. Program methods and materials are now available to other diabetes educators by email or diskette and will soon be available on the ASU web page. The number of patients with diabetes in the target population is estimated at 86 for the past year. All of our patients are American Indian, from numerous tribes around the country, but they are predominately Rio Grande Pueblo and Navajo people. Most speak English; some elderly are most comfortable using their own language and some speak no English. Each tribe has their own language. This population has a strong oral tradition and the literacy level has been estimated to be low. A large number live below poverty level.

- Participant access and follow-up mechanisms

Participants access the program through medical provider referral. Appointments are made through the AIH appointment system. Follow-up is done 2-3 months after the fifth education visit. Case management of newly diagnosed patients is established and is used as a mechanism for following individuals. This year we will be utilizing a software program, Basics *Plus* to track patients through the education program. People who miss appointments are contacted by letter or phone call to reschedule their appointments. If a follow-up appointment is not feasible, the session can be done by

phone call. This will include providing arrangements for having follow-up lab work (Hemoglobin A1c) done. The patient's primary provider will be notified regarding completion or non-completion of the program.

- Instructional Methods

Newly diagnosed patients are currently seen for a series of 6 one-to-one sessions. The first session includes assessment and introduction to the program. There is a curriculum to follow for each session, but sessions are adapted to best meet patient needs. Patients set behavioral goals, which are assessed at each visit. We will be converting to more group education so we will be able to collect reimbursements for eligible patients.

- Resource Requirements

Staffing and space requirements are adequate, but the education clinics are still not in a permanent location and space for storage of materials is in another building. There are not adequate facilities in our current location for use of alternative teaching methods, such as videotapes or computer instruction. One of our nurse educator positions will be vacant next month.

- Outcome Measures

Outcome measures will remain the same as for the past year – behavioral goals and pre and post program HgA1c values. We will continue to have participants evaluate the program. The results of the outcome measures and HgA1c values will be reported to the advisory committee at the next annual review in March 2001.

The annual program plan for August 2001 – June 2001 is approved by the Advisory Committee and the Albuquerque Indian Hospital.

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Co-Chair, Advisory Committee Date

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Co-Chair, Advisory Committee Date

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Chief Executive Officer Date

Source: Albuquerque Service Unit Diabetes Program

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FY 2003 Program Objectives

Goal:
Provide quality diabetes education and services to patients and their families to help them stay healthy and to prevent or delay the complications of diabetes.

Objectives:

1. Complete criteria and apply for recognition for the IHS Integrated Diabetes Education Recognition Program for American Indian and Alaska Native Communities by June 2002.

2. DEPTH – Diabetes Education Path to Health
   At three to six months after completion of the DEPTH Program:

   - 75% of patients will have an A1c value of 7% or less
   - 50% of patients will attend their follow-up session three to six months after completing the DEPTH Program
   - 75% will have met their personal exercise goals
   - 90% will be doing self-blood glucose monitoring on a regular basis
   - 95% of patients will have an annual eye, dental, foot (neuro), and urine microalbumin completed within the last year
   - 90% will have an annual nutrition visit

Objective #1: Measure HgbA1c in all enrolled patients on or within one month of the first educational session. Measure HgbA1c three months after completion of all educational objectives. Compare pre and post-objective values.

Objective #2: Document the number of enrolled patients completing all education objectives and who also keep their three to six month follow-up session. Compute percent.

Objective #3: Document status of exercise behavior change goal made at completion of education objectives and document verbal report of this goal. Evaluate achievement of personal exercise goal. Compute percent.

Objective #4: Document status of the number of enrolled patients doing self-blood glucose monitoring on a regular basis, a minimum of 6 times per week. Compute percent.

Objective #5: Document the number of enrolled patients completing the self-care program who had their annual eye, dental, foot (neuro) and urine micoralbumin test done within the last year. Compute percent.

Objective #6: Document the number of enrolled patients completing the self-care program who received an annual nutrition visit by a dietitian. Compute percent.

Source: Phoenix Indian Medical Center DEPTH Program